Respiratory Update

September 2004

President's Message

Scott J. Svonkin
President

With much of this year already behind us, I am able to sit back and reflect upon the many challenges we've overcome and successes we've achieved. Two of the most important successes that come to mind, are the Board's decision to hold a meeting in conjunction with the California Society for Respiratory Care's Annual Conference and our legislative success. You may wonder why I feel these were so substantial? Well, holding our meeting was important in many ways. First, it marked an historical event for the Board as the first time it has ever held a meeting in conjunction with a CSRC sponsored event. I think this shows a great deal about how far we've come in strengthening our working relationship and acknowledging our common goals. In fact, I felt this event was so important that I did not even bat an eye when I had to catch a "red-eye" flight after attending a hearing in Washington, D.C. to ensure I was able to interact with so many members of the profession. Our legislative victory may not be as important as when the board was created but it shows that we are focused on working with the legislature to improve the profession and protect consumers. While I'm sure the excitement of this joint meeting was on the mind of everyone involved, the day's events were inevitably bitter-sweet. You see, it was also during this meeting the Board said good-bye to Eugene Mitchell, whose resignation from the Board was prompted by his appointment to the Little Hoover Commission. While the Board is extremely proud of Mr. Mitchell for being selected by Governor Schwarzenegger to serve in such an important role, it did not make his departure any less difficult. The only consolation was the opportunity the Board was given to acknowledge Mitch, as a great member, colleague, individual and friend at a prestigious statewide professional event.

During his tenure with the Board, Mr. Mitchell also served alongside me on the Legislative Committee. I am pleased to report that through negotiations with the Senate Business and Professions Committee and the CSRC, the Legislative Committee was successful in having several Board approved legislative amendments placed in SB 1913. Two of the more significant amendments include clarifying the scope of practice as it relates to ventilatory support and establishing authority for staff to process stipulated agreements for the issuance of "public reprimands" for qualifying cases. While the Law and Professional Ethics course remains a top priority for the Board, due to an unforeseen legislative delay, the estimated implementation date of the course requirement has been extended. This issue will continue to be discussed at upcoming meetings and will be reported upon in future editions of the Respiratory Update.

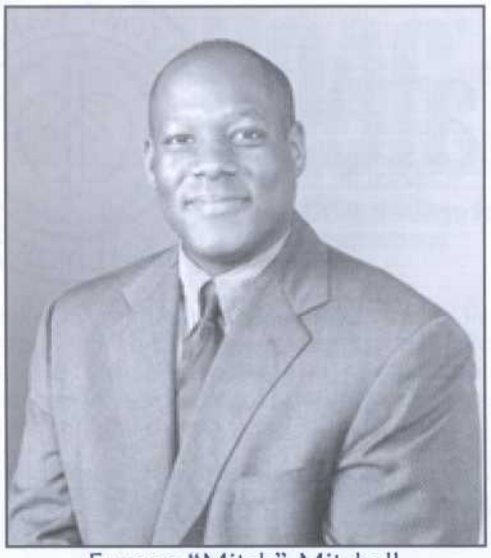
Throughout my Presidency I have had the opportunity to witness the dedication and commitment my fellow members continually demonstrate. With that said, I would like to take this opportunity to specifically recognize the endeavors of the two members of the Professional Licensing Committee, Richard Sheldon, M. D. and Larry Renner, RCP. Dr. Sheldon and Mr. Renner have worked very diligently throughout this year to address the potential need for regulation of the practices of polysomnography, pulmonary function testing and hyperbaric oxygen therapy. In addition, staff has commenced regular meetings with representatives of the Department of Health Services allowing for review of agency or section responsibilities and for increased awareness of the unlicensed practice of respiratory care in the home care setting.

Mr. Renner should also be praised for his development of an exceptional DVD presentation which will soon be available for use as an outreach tool. As previously reported, due to budget constraints the Board's outreach efforts have been drastically reduced. However, Mr. Renner's willingness to develop this presentation on his own time demonstrates his personal dedication to the profession. On that note, I would also like to extend continued appreciation to the CSRC for agreeing to step in and coordinate attendance at various career events. These actions are also clearly reflective of the CSRC's commitment to professional advancement and are appreciated by the Board.

I continue to look forward to the many tasks before us. We face many current challenges, but I am confident that with the hard work of this Board, supported by the efforts of dedicated staff, our achievements will be numerous.

Inside This Issue

Published by the Respiratory Care Board of California, 444 North 3rd Street, Suite 270, Sacramento, CA 95814
Telephone: (916) 323-9983 Toll-free: (866) 375-0386 Fax: (916) 323-9999 E-mail: rcbinfo@dca.ca.gov Web: www.rcb.ca.gov



Eugene "Mitch" Mitchell

Farewell to Eugene "Mitch" Mitchell, Exemplary Public Member

The Board honored Eugene "Mitch" Mitchell at its June meeting held in San Diego, and presented him with a plaque for his 5+ years of dedicated service as a public member of the Board. Mr. Mitchell was initially appointed by Governor Pete Wilson in 1999 and was reappointed by Governor Gray Davis in 2001. Mr. Mitchell served in numerous capacities, most notably his leadership role as Vice President in 2000 and 2001 and was instrumental in negotiating many of the Board's successes. Members and staff expressed their admiration for his integrity, judiciousness, openness, ability to compromise and dedicated work ethic and conveyed their trust in and respect for him.

In April, Governor Schwarzenegger appointed Mr. Mitchell to the Little Hoover Commission, an independent state oversight agency. It was due to that appointment that Mr. Mitchell tendered his resignation as a member of the Board. The mission of the Little Hoover Commission is to investigate state government operations and promote efficiency, economy and improved service. Mr. Mitchell was appointed to the Commission in time to fully participate in the California Performance Review, a project intended to help the Governor and Legislature develop a roadmap for structural reform of State government.

While members and staff will sincerely miss him, they believe the Governor has made an excellent selection and recognize Mr. Mitchell's need to direct all his energy and focus toward his new appointment. The Board and staff wish him many successes in all his future endeavors!

Survey to Be Released 9/1 -Opinions & Input Needed!

Per the Joint Legislative Sunset Review Committee's 2002 recommendation, the Board continues to research the issues of unlicensed personnel in the practices of polysomnography, pulmonary function testing and hyperbaric oxygen therapy. Many state and national associations are also looking at these issues raised by the Board, knowing that they are nationwide concerns.

The Board is aware of only a handful of states who have addressed some of the issues surrounding polysomnography. Idaho requires a person to either be a licensed respiratory care practitioner or hold a "permit," issued by the respiratory board, in order to practice polysomnography. Wyoming's laws require a person to be a licensed respiratory care practitioner to practice polysomnography. There are also a handful of other states who have opted to give exemptions from their respiratory care practice act to persons who are privately credentialed in polysomnography. While, other states continue to weigh in on this issue.

Several states are considering issues in regard to pulmonary function testing. While most state's respiratory care scope of practice acts include pulmonary function testing, several states are addressing whether or not basic spirometry testing should be exempted and/or have not taken action against unlicensed personnel performing various tests.

It appears the concerns surrounding unlicensed personnel providing hyperbaric oxygen therapy have not yet been raised by any state other than California. As with all of these practices, there are serious concerns with the health and safety of patients who are receiving treatment, or lack thereof, by personnel who are not qualified to provide care.

What do you think? The Board has developed a comprehensive survey with sections for each practice (polysomnography, pulmonary function testing and hyperbaric oxygen therapy) and expects to release the survey on or before 9/1/04. The survey will be sent to all of you who notified us of your interest to participate, as well as all California program directors, numerous professional and consumer advocacy associations, and hundreds of independent facilities. The survey will also be made available on our website, with the ability to print a hard copy to mail to the Board, or, if you have Microsoft Word, a soft copy for electronic submission (via e-mail).

The Board wants and needs your input so that it can make informed recommendations to the Joint Legislative Sunset Review Committee next year. All submissions received by November 1st will be reviewed by the Board and reflected in its final report. Please visit our website at www.rcb.ca.gov and complete one or more sections of the survey. We value and need your opinions and input!

New Continuing Education Requirements in Effect

The Board's new and revised continuing education (CE) regulations were approved last May. As of the publication of this notice, all CE taken to meet renewal requirements, must meet the new criteria.

The new regulations continue to require a total of 15 hours of CE every two years with a minimum of 2/3 (10 hours) being directly related to clinical practice while the other 1/3 (5 hours) may be related to the general practice of respiratory care. The most significant changes now require courses to be approved or provided by recognized entities and limit the credit granted for repeating examinations and courses in connection with credentials and certifications.

To review all of the requirements and complete regulatory language, please log on to our website at: www.rcb.ca.gov and click on "Laws/Regulations."

Following are highlights of the new requirements:

♦ All CE courses must be approved by or provided by one of the following recognized organizations:

1) Any post-secondary institution accredited by a regional accreditation agency or association recognized by the United States Department of Education.
2) A hospital or healthcare facility licensed by the California Department of Health Services.
3) The American Association for Respiratory Care.
4) The California Society for Respiratory Care (and all other state societies directly affiliated with the American Association for Respiratory Care).
5) The American Medical Association.
6) The California Medical Association.
7) The California Thoracic Society.
8) The American College of Surgeons.
9) The American College of Chest Physicians.
10) Any entity approved or accredited by the California Board of Registered Nursing or the Accreditation Council for Continuing Medical Education.

♦ Successful completion of each of the following examinations in connection with a course approved by one of the above entities may be counted only once for credit (towards any of the required CE hours) and must be for initial certification. However, repeating or "recertifying" in one of these areas may be counted towards the 5 hours of CE that is *not* required to be "directly related to clinical practice."

- Advanced Cardiac Life Support (ACLS)
- Neonatal Resuscitation Program (NRP)
- Pediatrics Advanced Life Support (PALS)
- Advanced Trauma Life Support (ATLS)

♦ Passing one of the following examinations offered by the National Board for Respiratory Care continues to be accepted for 15 hours of credit (directly related to clinical practice), but may now only be counted once for credit.

- Registered Respiratory Therapist (RRT)
- Certified Pulmonary Function Technologist (CPFT)
- Registered Pulmonary Function Technologist (RPFT)
- Neonatal/Pediatric Respiratory Care Specialist (NPS)

Licensees (as well as providers) are still required to maintain proof of completion for CE courses completed for a period of 4 years. Proof of completion now includes identification that each course was provided by or approved by one of the aforementioned organizations.

Audits are performed by Board staff on approximately 5% of renewals randomly selected each month. Those licensees are sent a request for proof of completion certificate(s), which allows Board staff to verify those courses. Regulatory language continues to provide that, "If documentation of the CE requirements is improper or inadequate, or the licensee fails to provide the requested documentation within 30 days, the license becomes inactive. The practice of respiratory care, or representation that one is an RCP, is prohibited while the license is inactive." However, a new provision provides that if the Board determines, through no fault of the licensee, the CE does not meet the criteria set forth in the CE requirements, the Board may grant an extension, up to 6 months, to complete approved CE.

Any questions regarding the new CE requirements may be directed to the Board's Licensing Unit.

2004 BOARD MEETING, STRATEGIC PLANNING SESSION RESCHEDULED

The Board's next strategic planning session and meeting, originally scheduled to be held in October, have been rescheduled as follows:

Board Meeting
Monday, December 13, 2004
San Jose

The strategic planning session will be held in 2005. The specific date and location of the strategic planning session will be scheduled at the December 13th Board meeting.

All meetings (including strategic planning sessions) are open to the public. Please visit our website at www.rcb.ca.gov for more information on meeting dates, times and locations. Agendas for upcoming meetings are posted 10 days prior to meeting dates.

The Board welcomes and encourages your attendance!

Quick Updates

Law and Professional Ethics Course. Due to an unforeseen legislative delay, the estimated implementation date of the Law and Professional Ethics course requirement has been extended beyond 2005. Additional information regarding the requirement will be discussed at future meetings.

Exam Equivalency. The Board has begun the regulatory process to define "exam equivalency" for individuals applying for licensure who possess a credential issued by the NBRC. Proposed regulations are available on the Board's website under the "Laws/ Regulations" link.

Applicant Disciplinary Assessment. In addition to the In-House Review/Penalty Guidelines, the Board's website will soon include a variety of application scenarios that can be used by students or applicants to help determine what level of discipline, if any, would be assessed for prior criminal convictions.

The Respiratory Care Board of California

Pictured from left: Gopal D. Chaturvedi; Kim Cooper Salinger, MBA, RRT, Vice-President; Scott J. Svonkin, President; Barbara M. Stenson, RCP; past member Eugene W. Mitchell; Larry L. Renner, RCP; Gary N. Stern, Esq., and Richard L. Sheldon, M.D.

2004 Legislation. The Board is watching the following legislative bills of interest: AB 2185 Asthma Treatment Care; AB 2366 Registration Fees: Additional: Pollution Control; AB 2436 Clinical Laboratory Testing; SB 1912 Pupil Health: Self Administration of Medication; AB 2132 Pupil Health: Self Administration of Asthma Medication, and AB 2367 Pupil Health: Asthma. Specific information regarding these bills is available at www.leginfo.ca.gov.

Home Care

Since the 1980s, there has been a growing trend towards home care and the home use of sophisticated medical devices by unqualified caregivers. As a result, patient care and the safety and effectiveness of medical devices, as they pertain to respiratory care, have declined, jeopardizing respiratory patients' health, safety and welfare, and home care cost savings have not been fully realized.

Currently, decisions about releasing patients from hospitals to home care are frequently made without adequate assessment of the capability of home caregivers or the suitability of the home environment. The "home" is a unique setting for medical care that is incredibly difficult to regulate compared to care provided in a managed facility. Currently in California, the Department of Health Services regulates Home Medical Device Retail Facilities (HMDRFs) and Home Health Agencies (HHAs). However, the existing laws and regulations for services provided by these companies do not recognize the need for formal education, training and competency testing as it pertains to respiratory care and the use of respiratory medical devices.

The practice of respiratory care by persons other than licensed respiratory care practitioners or others who hold an exemption in the Act, is illegal. It is a criminal offense and punishable by a fine not to exceed one thousand dollars and/or imprisonment in a county jail up to 6 months for each offense.

In California, "home medical device" as defined in the Health and Safety Code, includes oxygen delivery systems and prefilled cylinders, ventilators, CPAPs, respiratory disease management devices, apnea monitors, and low air loss continuous pressure management devices. Many devices require higher levels of cognition, memory, and decision-making and/or physical tasks for their proper operation. The use of respiratory care devices is governed by the Respiratory Care Practice Act and requires licensure as a respiratory care practitioner, being another qualified licensed professional, or being a person exempted from the Act. Self-care by the patient or the gratuitous care by a friend or member of the family is one of those exemptions. The practice of respiratory care by persons other than licensed respiratory care practitioners or others who hold an exemption in the Act, is illegal. It is a criminal offense and punishable by a fine not to exceed one thousand dollars and/or imprisonment in a county jail up to 6 months for each offense.

Unlicensed personnel employed by HMDRFs are providing patient care. In addition to reports of such activities, it would be unreasonable to think that a HMDRF would dispense a sophisticated device by simply explaining to a lay caregiver how to turn the machine off and on and explain the many facets of the device. The reality is that many HMDRFs are dispensing sophisticated devices and then providing care by adjusting settings as prescribed and/or providing consultation to the family to not only include how the machine operates but also in reference to treatment of the patient. In most cases, patient care is being provided by equipment delivery personnel who are not qualified or authorized to do so. Such personnel are legally limited to delivering equipment, setting up the equipment (not to the patient), and instructing the patient or caregiver on how to operate the equipment from a mechanical perspective.

The laws governing HMDRFs primarily address the handling, care and operation of equipment - not patient care. However, the DHS' HMDRF unit shares the Board's concern for patient safety and has willingly agreed to review patient care/unlicensed practice complaints during regularly scheduled or enforcement-related inspections. Board staff refer complaints to the DHS and then obtain status checks regularly.

Unlike the regulation of HMDRFs, HHAs are mandated to provide patient care and are required to hold accreditation by

either the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the Community Health Accreditation Program (CHAP). It is believed that this component has made the unsafe practice of respiratory care less prevalent among Home Health Agencies.

HHAs are required to have an RN or occupational, physical, or speech therapist oversee all treatment plans (within each professional's scope of practice). However, care may be performed by an LVN, home health aide or "other non-licensed personnel." The most common complaint received regarding HHAs is that personnel, whether licensed or non-licensed, are not familiar with respiratory medical equipment and are not educated or trained to respond to unusual situations, or how to use the medical equipment to allow the patient to receive the most beneficial treatment. While the course load for minimum education for licensure as an RN (58 semester units) is nearly the same as an RCP (Associate Degree, 60-75 units), the component of respiratory care is only touched upon in a nursing program. An Indiana University Study by Robert Czachowski, Ph.D., titled, *Study Finds Respiratory Care Instruction Very Limited in Nursing Schools,* found that the entry-level RN will have had extremely limited didactic instruction in the 15 typical respiratory therapy procedures included in the survey. "The significance of that difference is magnified when compared to respiratory therapy programs... Factoring in the number of programs that do not even address some of these respiratory therapy tasks, there should be real concern about arbitrarily transferring respiratory care responsibilities..." In comparing these "15 typical respiratory therapy procedures," it was found that the "mean" time spent teaching "mechanical ventilators" and "oxygen therapy" was:

	Mechanical Ventilators			Oxygen Therapy		
	Classroom Hrs.	Lab Hrs.	Clinical Hrs.	Classroom Hrs.	Lab Hrs.	Clinical Hrs.
Associate Degree Nursing Programs	1.6	.71	10.2	2.4	1.8	21.2
Diploma (3-year) Nursing Programs	2.2	1.3	41.5	2.7	1.5	68.7
Baccalaureate Degree Nursing Programs	1.5	.72	14.9	2.46	2.0	24.4
Respiratory Therapy Program	**44.8**	**33.00**	**227.8**	**18.69**	**13.2**	**67.37**

The study reported "it is clear that entry-level nurses who do not obtain significant postgraduate education cannot perform respiratory care procedures."

It should be noted that some HMDRFs and HHAs hire RCPs because they strive to provide optimal patient-care and they see the benefit of having an expert on staff to address respiratory problems and oversee respiratory medical devices. Likewise, they also understand the liabilities of not having an RCP on staff. HMDRFs and HHAs receive no reimbursement specific to RCP services.

Another factor to consider is the dispensing of oxygen cylinders, one of the most frequently dispensed devices. There have been several warnings issued in relation to the improper handling of oxygen and medical gas mix-ups resulting in unnecessary fatalities. Due to continual injuries that occur from improper handling, it would be beneficial to have a licensed professional (i.e. RCP, RN, LVN), who has both education and training in this area, on staff for education and consultation. Moreover, a study conducted by three physicians, titled, "Implementation of an Oxygen Therapy Clinic to Manage Users of Long-Term Oxygen Therapy," revealed significant cost savings and improved patient outcomes when using an RCP as part of the treatment plan.

In addition to regulatory controls, reimbursement, or the lack of it, drives the existing home care practice. The Federal government is just beginning to recognize that the practice of respiratory care is a specialized field and that respiratory treatment by a licensed RCP improves patient care, and has financial incentives for health insurers. Pending Federal legislation (H.R. 2905) would amend the Social Security Act to recognize the services of respiratory therapists under Medicare's home health services benefit. This bill will not have any impact on payment, but rather adds respiratory therapists to the list of providers that may be reimbursed for respiratory care. If enacted, this bill will increase consumer protection by making it an incentive for HHAs to provide optimal care for respiratory ailments, which will likely lead to a decline in emergency room visits, shorter stays, and less readmissions.

However, HMDRFs were hit with reductions in reimbursement rates for durable medical equipment as part of a trailer bill to the State's 2003-2004 budget. This bill provides that reimbursement for durable medical equipment shall be reduced to 80% of the lowest maximum allowance for California established by the Federal Medicare program (or any other lower rate as described) and that reimbursement for monthly rental charges shall cease after 10 months. Thereafter, the provider shall continue to provide the equipment without charge until the medical necessity ends or Medi-Cal coverage ceases.

As previously mentioned, there are many reputable HMDRFs and HHAs who recognize the benefits of using an RCP in the interest of patient safety and optimal patient outcomes, regardless of the fact that they do not receive reimbursement. Yet it is believed that the majority of providers are driven more by financial gain rather than patient care. Therefore, because there is no mandate to require the use of, and no reimbursement for services provided by, an RCP, many HHAs and HMDRFs do not hire them, and the potential for costs savings while providing optimum care is negated.

In response to recommendations made by the Joint Legislative Sunset Review Committee, chaired by Senator Liz Figueroa (*D-Sunol*), the Board's Professional Licensing Committee (Larry L. Renner, RCP, Chair; Richard L. Sheldon, M.D., Member) is reviewing the issue of respiratory care provided in the home. In November 2003, a draft 15-page report was presented to the Board outlining concerns with home care and proposed solutions for consideration. In June, Board staff commenced regular meetings with representatives from the Department of Health Services' Home Medical Device Retail Facilitates Section, Medi-Cal Division, and the Children's Medi-Cal Services Branch. These meetings have allowed for review of agency or section responsibilities and for increased awareness of unlicensed practice of respiratory care in the home care setting. The Professional Licensing Committee expects to complete its report in 2005 for presentation to the Joint Legislative Sunset Review Committee.

Gloria "Jean" LeBlanc, RCP

Gloria "Jean" LeBlanc Recognized, Exemplary Service

The Board was honored to recognize Gloria "Jean" LeBlanc for her significant contributions and dedication toward the practice of respiratory care at its June 24th meeting in San Diego. Numerous colleagues of Ms. LeBlanc's at Scripps Memorial Hospital-La Jolla, attended the ceremony where Barbara Stenson, RCP, Member, presented Ms. LeBlanc with a plaque on behalf of the entire Board honoring her recognition.

Ms. Stenson noted that the nomination clearly depicted Ms. LeBlanc as an exemplary RCP, deserving of recognition. The nomination described Ms. LeBlanc as a clinically-skilled and detail-oriented RCP who is diligent in her practice and dedicated and proud of her profession. She makes herself available for community projects and comes in on her own time to keep abreast of current information. She has retained her membership in the CSRC and attends major clinical conferences regularly.

Ms. LeBlanc is a leader in the pursuit of lifelong continuing education and obtaining advanced credentials by focusing on raising the quality of delivered patient care. Ms. LeBlanc has earned the ACLS and NRP providerships and is currently completing coursework to sit for the RRT examination.

Ms. LeBlanc leads by example and is the epitome of a team player. She is responsible, trustworthy and graceful in her demeanor, every day. Jean serves as a role model and resource to members of the interdisciplinary team, RCP staff, students and orientees. Patients have specifically requested her to care for them and staff try to schedule their days to work with her. Her personal charm and quality is engendered throughout her practice, resulting in grace under pressure. She accepts assigned responsibility and seeks support to overcome any barrier that might negatively impact delivered care. She utilizes her own time to better understand challenges her patients may encounter. She regularly shares additional information with other members of the department, thereby raising the administration's ability to manage rare maladies.

Ms. LeBlanc is extremely resourceful, and valued and respected by her patients, peers, and administration. Clinicians like Ms. LeBlanc reduce the fears and anxiety of patients and peers by their presence, intelligence and dedication. Ms. LeBlanc may only be known to those of the healthcare community in San Diego, but she should be celebrated by all for her gifts, because she represents the greater RCP Community.

License Verification Available Online!

You can verify licensure status online via the Board's website at www.rcb.ca.gov. The online license verification system is available 24 hours a day, 7 days a week and records are updated daily (M-F).

Scholarships New!

The Board has added a segment to its website to provide information about available scholarships. Currently, the home page has a link to information about scholarships being offered by the California Thoracic Society (CTS). The CTS is offering $1,000 scholarships to new and first year respiratory therapy students. ***But hurry! The deadline to submit an application is September 30th.***

If you are aware of similar scholarships, please let us know so we can post these on our website and make mention of them in our newsletters.

Career Outreach, DVD Presentation

At the Board's meeting held June 24th, member Larry L. Renner, RCP, presented a DVD he developed as an outreach tool. The DVD includes a wealth of detailed information ranging from historical facts to employment outlook to the licensing process.

The DVD is expected to be finalized by December and will be made available through the Board's website for anyone considering a career in the respiratory care profession. The DVD will also be distributed to California respiratory programs and the California Society for Respiratory Care, which tirelessly work to recruit students into the profession.

RCP Recognition Nominations

Do you know a respiratory care practitioner who has extended an extra measure of care? The Respiratory Care Board would like you to nominate a member of the respiratory care community who deserves recognition for rendering exceptional service and care to a patient, colleague or the profession. The established criteria for recognition include values relative to service, dignity, responsibility, teamwork, trust, and accountability.

Help the Board identify and recognize deserving practitioners by completing a nomination form available on the Board's website at www.rcb.ca.gov. Nominations can be electronically submitted, or you may print a copy of the nomination form, which can then be completed and returned via fax or mail.

Once the Board has received a minimum of 5 individual nominations, it will review each nomination and vote on who is most deserving of recognition based on the established criteria and how the individual's accomplishments relate to the mission of the Board. The individual will then be recognized, on behalf of the entire respiratory care community, at a future Board meeting and in an upcoming edition of the *Respiratory Update*.

Proposed Legislation Clarifies, Ventilatory Support, Provides Cost, Time Saving Measure

Senate Bill (SB) 1913 provides several proposed amendments to the Respiratory Care Act (Act). Two of the proposed addendums to SB 1913 will clarify the scope of practice as it relates to ventilatory support and grant the Board authority to establish an in-house process to "stipulate" to a "public reprimand" for some disciplinary matters affecting licensees.

In 1982, when the Respiratory Care Practice Act was enacted, the Legislature recognized, "the practice of respiratory care to be a dynamic and changing art and science, the practice of which is continually evolving to include newer ideas and more sophisticated techniques in patient care." The American Association for Respiratory Care notes in its white paper titled, *Development of Baccalaureate and Graduate Degrees in Respiratory Care*, (circa 2003), that, "...the results of twenty [20+] years of expanded clinical research have empowered respiratory therapists with additional therapeutic techniques, medications, and medical devices used to evaluate and treat patients with increasingly complex cardiopulmonary disorders.... There has been the birth of critical care medicine, pulmonary rehabilitation, and neonatology, as well as advances in cardiovascular diagnostics, sleep-disorders, and emergency transport. The advent of therapist-driven protocols, emphasis on patient outcomes and evidence-based medicine reflect this continuing transformation."

One such foreseen advancement is in the medical devices used to deliver ventilatory support. Currently, the Act provides that "mechanical or physiological ventilatory support" is within the scope of practice of respiratory care. While "mechanical or physiological ventilatory support" includes any type of ventilatory or oxygenating support, the term "mechanical ventilator" has been used for decades lending a preconceived image of a mechanical ventilator which could cause confusion with future technologies providing "mechanical ventilatory support."

While mechanical ventilators have dramatically reduced in size and made significant improvements towards patient safety, they all continue to require a cannula or tube to deliver ventilatory support. However, a new device has been developed, which is expected to enter the market within the next 5 years, which does not fit the stereotypical image of a "mechanical ventilator." Specifically, a new device calls for the insertion of a catheter rather than the cannula or tube to deliver ventilatory support. While both devices are connected to a machine or device controlling ventilatory support, and both would be considered "mechanical ventilatory support," the catheter will, in all likelihood, not be perceived or referred to as a "mechanical ventilator," thereby, raising question to the respiratory care scope of practice. The proposed addendum will prevent such an exclusion and provides,

> " Mechanical or physiological ventilatory support... includes any system, procedure, machine, catheter, equipment, or other device used in whole or in part, to provide ventilatory or oxygenating support."

The Board hopes that providing clarification on ventilatory support, will assist medical facilities and other organizations to move forward as new ideas and technologies are introduced.

The Board hopes that providing clarification on ventilatory support, will assist medical facilities and other organizations to move forward as new ideas and technologies are introduced.

Another proposed addendum will authorize the Board to establish an "in-house" process with which to stipulate to a "public reprimand" for some licensee disciplinary cases. Currently, in order to issue a "public reprimand," board staff must refer a case to the Office of the Attorney General for the filing of an accusation and then, stipulate to a "public reprimand." This practice is costly to both the board and the licensee and lengthy, anywhere from 3 to 9 months. The proposed addendum provides,

> "...the board may, by stipulation with the affected licensee, issue a public reprimand, after it has conducted an investigation, in lieu of filing or prosecuting a formal accusation." The licensee shall be advised of his/her rights to have a formal accusation filed and stipulate to a settlement thereafter or have the matter heard before an administrative law judge. Such an action "shall be public information and shall be used as evidence in any future disciplinary or penalty action taken by the board."

This proposed addendum would allow board staff to work directly with licensees (willing to stipulate) to the same end result with no Attorney General costs and in a more timely fashion, estimated at less than 30 days from the point the case would have been forwarded to the Office of the Attorney General.

If SB 1913 is successful, these legislative changes will take effect January 1, 2005.

We Want to Hear from You

If you have issues, concerns or ideas you think would better serve the consumers of California or the respiratory care profession, we want to hear from you. E-mails can be addressed to rcbinfo@dca.ca.gov.

Revenues & Expenditures

The Board has completed its preliminary year-end financial reports for fiscal year 03/04 (July 1, 2003 - June 30, 2004). Expenditures were reported at $2,210,000 and revenues at $2,169,000. While expenditures continue to exceed revenues, the Board's reserve fund is sound with a balance of $1,064,000 after absorbing this $41,000 difference.

The Board has been successful in implementing several measures to increase revenues and reduce expenditures. To name a few, last fiscal year, the Board implemented its cite and fine program, contracted with a private agency to drug test probationers (as required), developed a billing system to provide regular invoices to those owing monthly probation monitoring costs and/or cost recovery and commenced, via a private agency, the collection of outstanding costs (primarily from cost recovery ordered in relation to disciplinary cases). The Board also lost 2 staff persons due to impending layoffs. Unfortunately, there will not be sufficient time to fully realize the positive impact of these measures due to increases in costs outside the Board's control.

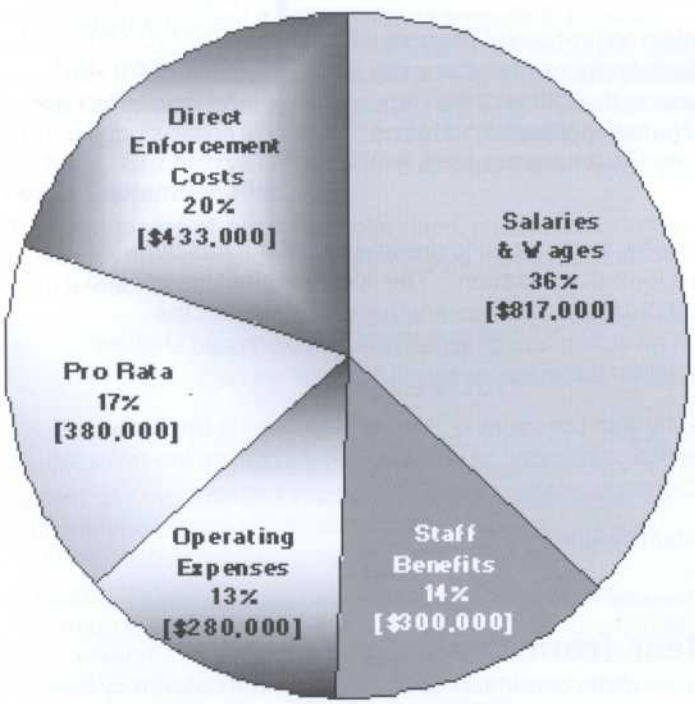
Rates for the Office of the Attorney General (OAG) and the Office of Administrative Hearings (OAH) have significantly increased this year. The Board is required to utilize the services of the OAG and the OAH when an enforcement case warrants formal disciplinary action. The Office of the Attorney General's attorney rates increased from $112 to $139/hr (25% increase) and paralegal rates climbed from $53 to $91/hr (72% increase). Since more than half of the Board's cases are handled by paralegals, the Board can expect to see a significant increase in OAG costs per case, though the Board believes the implementation of its citation and fine program will ease the overall impact. The Office of Administrative Hearings' Administrative Law Judge rates increased from $161 to $169/hr (5% increase).

Rise in health care costs are responsible for significant increases in the Board's contributions toward staff benefits (and employee out-of-pocket costs) as of January 1, 2004. Staff salaries and benefits are established through negotiations between the employees' union and the State. In FY 02/03, staff benefits totaled $236,000; this included benefits for two additional staff members that are no longer employed by the Board. The cost for staff benefits in FY 03/04 was $300,000. A 27% increase.

The Board continues to explore ways to reduce costs and is reviewing other state respiratory care agencies to find better processes. In a preliminary review, the Board found that the State of Florida provides comparable services but their renewal fee is among the highest at $200. The Board found other states with lower fees most often were not paying "pro rata," had very little enforcement action, were a component of a larger organization who shared resources, and/or were not required to use the Administrative Hearing process (like the California Board) unless a case was appealed. Earlier this year, Governor Schwarzenegger initiated the "California Performance Review," for the purposes of reforming and revitalizing State government. The Board is hopeful that changes resulting from this review will ultimately reduce the Board's expenditures. The review will be realeased to the Governor and the public once the State Budget has been passsed.

While the Board continues to look for avenues that can lead to reduced expenditures, it welcomes and encourages any information or ideas you can share. Please submit items to the attention of Stephanie Nunez, Executive Officer, via e-mail: rcbinfo@dca.ca.gov.

Fiscal Year 03/04 Expendiitures



Direct Enforcement Costs includes expenditures for the Office of the Attorney General, the Office of Administrative Hearings, and investigative and expert witness services.

Salaries & Wages includes staff salaries and member per diem. The Board currently has 18 staff members assigned in program areas as follows: Administration (5), Licensing (3), and Enforcement (and Probation) (10)

Staff Benefits includes the Board's contributions towards staff medical, dental and vision insurance and staff and member retirement.

Operating Expenses includes expenditures for printing, postage, telecommunications, facility rent, travel, office supplies, equipment, staff training, license database access, fingerprints, examinations, and membership dues.

Pro Rata includes assessments from the Department of Consumer Affairs and the State of California for the availability and/or use of services from: PC/LAN Support Unit; Internet Support Unit; Division of Investigation; Communication and Education Division; Consumer Relations & Outreach; DCA's Personnel, Budget, Purchasing, Contracts, and Legal Offices; the State Personnel Board; Department of Finance; the State Controller; the State Treasurer; the Legislature, and the Governor's Office.

The Disciplinary Process, Stay Involved!

You've just been arrested for a crime or have been disciplined at work and you're overwhelmed with grief over how this will affect your license and livelihood. This is generally the sentiment of licensed practitioners who have exercised poor judgment either at or away from work. The Board's mandate coupled with the nature of the respiratory care practice is the basis for the Board to consider each violation of the Respiratory Care Practice Act (Act) very serious. In a case where the Board decides to pursue formal disciplinary action, the licensee named needs to stay involved in the process in order to make an impact on the level, if any, of discipline ordered.

The Board realizes that the vast majority of its licensed professionals respect their profession and take pride in helping their patients. However, some of these same professionals may show a temporary lapse in judgement, generally related to an isolated incident, which often results in a criminal conviction. Yet there are others who may lack the foundation, character traits, or skills necessary to conduct their lives in a law abiding manner. They may simply decide to violate the law with no regard for others. Still, others may be law abiding citizens and take absolute pride in their profession, yet demonstrate incompetence or negligence in providing respiratory care. This may be a result of a temporary lapse in judgement or indicative of more significant care issues.

"...Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount."

The Board is mandated to "protect the public from the unauthorized and unqualified practice of respiratory care and from unprofessional conduct by persons licensed to practice respiratory care." In addition, another law, authored by Assemblyman Lou Correa (D-Santa Ana), went into effect in 2002 and provides that "protection of the public shall be the highest priority for the Respiratory Care Board of California in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount." The Board also recognizes that the respiratory care profession is a distinct profession requiring critical-thinking and decision-making skills and specialized and intense education and training to competently provide care for a myriad of respiratory ailments afflicting patients of all ages and under various conditions - from newborns to the elderly, ICU and end-of-life patients and in emergency situations. For these reasons, the Board must review and consider all aspects of every case very carefully throughout the complaint, investigative and disciplinary processes.

Information concerning violations made by respiratory care practitioners (RCPs) is received by the Board through a number of mechanisms (i.e. patient/RCP reporting, rap sheets, self reporting, mandatory reporting). Once the Board receives a complaint it is investigated by either Board staff or Board-affiliated peace officers. Findings of an investigation may be referred to an expert witness if a case involves a practice issue requiring an expert opinion. This information is then reviewed by Board staff to determine if a violation of the Act has occurred. If it is believed a violation has occurred, Board staff then use the Board's "In House Review/Penalty Determination" guidelines, and/or the Board's "Disciplinary Guidelines" to recommend the next course of action (both of these guidelines are available on the Board's website at www.rcb.ca.gov). Recommendations are reviewed by the Board's Enforcement Coordinator and, in some cases, by Board management.

Even if the RCP is not contesting the alleged violations, it is imperative for the RCP to complete and submit the "Notice of Defense" within 15 days, if he/she is going to participate in the disciplinary process.

Once it has been determined that formal disciplinary action will be pursued, the case is referred to the Office of the Attorney General for the filing of a formal accusation. The formal accusation, issued on behalf of the Board, is a public legal document that includes alleged violations of the Respiratory Care Practice Act. The RCP will be served by regular and certified mail with the accusation and a "Notice of Defense" at the last address of record (failure to have the correct address on record may result in a default decision that can not be rescinded). Even if the RCP is not contesting the alleged violations, it is imperative for the RCP to complete and submit the "Notice of Defense" within 15 days, if he/she is going to participate in the disciplinary process. Once the "Notice of Defense" is returned, the Deputy Attorney General (DAG) handling the case can begin settlement negotiations and/or set the case for hearing, on behalf of the Board.

...continued on page 16

Mission Statement

The Respiratory Care Board of California's mission is to protect and serve the consumer by enforcing the Respiratory Care Practice Act and its regulations, expanding the delivery and availability of services, and promoting the profession by increasing public awareness of respiratory care as a profession and supporting the development and education of all respiratory care practitioners.

Scope of Practice Inquiries & Responses

Inquiry: I am asking for a ruling regarding the practice of pulse oximetry performed by Medical Assistants on outpatients in the hospital setting for the purpose of qualifying or recertifying patients for home oxygen. Specifically, if the respiratory care practitioners are busy with inpatients and an outpatient arrives to the department with an order for pulse oximetry, is it acceptable for the department's Medical Assistant (who schedules the outpatient's appointments) to perform the pulse oximetry test? I am aware that Medical Assistants perform pulse oximetry routinely in physicians' offices. I just want to clarify if this is appropriate in the outpatient hospital setting as well.

Another issue I would like you to address is the fact that Medicare now requires three measurements of oxygen saturation when trying to qualify a patient for home oxygen using the exercise testing criteria. This criteria states that a patient's oxygen saturation must be measured: (1) at rest without oxygen (2) with exercise, but without oxygen, to demonstrate hypoxemia (3) with exercise, with oxygen applied, to demonstrate improvement of the hypoxemia. My additional question is: Is it acceptable for a Medical Assistant to place an outpatient on oxygen (per criteria 3 above) to demonstrate the improvement of the hypoxemia via pulse oximetry? A protocol approved by the Medical Staff/ and or Medical Director would be in place specifying that Medical Assistants could perform pulse oximetry on their outpatients. Again, I am aware that Medical Assistants occasionally place patients on oxygen in physician's offices. I just want to clarify if this practice is appropriate in the hospital outpatient setting as well.

Response: In our review of the laws and regulations governing medical assistants and additional information provided by the Medical Board of California (enclosed), we offer the following:

Question: Can a medical assistant practice pulse oximetry in the "outpatient" setting of a hospital?

Response: In our review of the laws and regulations governing medical assistants, we did not find where it is permissible for a medical assistant to perform pulse oximetry.

Whereas, section 3702 of the Business and Professions Code permits this practice by licensed respiratory care professionals who are highly educated and trained in the therapy, management, rehabilitation, and diagnostic evaluation of the pulmonary system and associated aspects of cardiopulmonary and other systems functions. Licensed professionals, such as respiratory care practitioners are educated and trained to ensure patient safety by providing accurate results and identifying hazards and complications, that if not recognized, could result in patient harm.

Please note the following laws and regulations governing medical assistants as it relates to this issue:

> Pursuant to section 2069 of the Business and Professions Code, "'Medical Assistant' means a person who may be unlicensed, who performs basic administrative, clerical, and *technical supportive services* upon the *specific authorization and supervision of a licensed physician and surgeon or a licensed podiatrist*[1] . . . ."
>
> Pursuant to Section 2071 of the Business and Profession Code, "The Division of Licensing [Medical Board of California] shall adopt and administer regulations that establish standards for technical supportive services that may be performed by a medical assistant. . . ."
>
> Pursuant to subdivision (b) of section 1366 of the California Code of Regulations, "*A medical assistant . . . may perform additional technical supportive services such as the following:*
>
> (1) Administer medication. . . .
>
> (2) Perform electrocardiogram, electroencephalogram, or plethysmography tests, except full body plethysmography.
>
> (3) Apply and remove bandages and dressings; apply orthopedic appliances such as knee immobilizers, envelope slings, orthotics, and similar devices; remove casts, splints and other external devices; obtain impressions for orthotics, padding and custom molded shoes; select and adjust crutches to patient; and instruct patient in proper use of crutches.
>
> (4) Remove sutures or staples from superficial incisions or laceration.
>
> (5) Perform ear lavage to remove impacted cerumen.
>
> (6) Collect by non-invasive techniques, and preserve specimens for testing, including urine, sputum, semen and stool.
>
> (7) Assist patients in ambulation and transfers.
>
> (8) Prepare patients for and assist the physician, podiatrist, physician assistant or registered nurse in examinations or procedures including positioning, draping, shaving and disinfecting treatment sites; prepare a patient for gait analysis testing.
>
> (9) As authorized by a physician or podiatrist, provide patient information and instructions.
>
> (10) Collect and record patient data including height, weight, temperature, pulse, respiration rate and blood pressure, and basic information about the presenting and previous conditions.
>
> (11) Perform simple laboratory and screening tests customarily performed in a medical office.
>
> (12) Cut the nails of otherwise healthy patients. . . ."

In an article published by the Medical Board of California titled, "Is your Medical Assistant Practicing Beyond His or Her Scope of Training" it is noted that:

> "...An unlicensed person may not diagnose or treat or perform any task that is invasive or requires assessment....
>
> Medical assistants are not licensed, and it is not legal to use them to replace highly trained, licensed professionals. The medical assistant is present to assist and perform support services in the physician's office.
>
> Those duties must be appropriate with the medical assistant's required training, which cannot be compared with licensed nurses or other health professionals who meet rigorous educational and examination requirements."

Question: Is it acceptable for a medical assistant to place an outpatient on oxygen per the following criteria you provided, to demonstrate the improvement of the hypoxemia via pulse oximetry? "This criteria states that a patient's oxygen saturation must be measured: (1) at rest without oxygen (2) with exercise, but without oxygen, to demonstrate hypoxemia (3) with exercise, with oxygen applied, to demonstrate improvement of the hypoxemia."

Response: Referencing the same information provided in the response above, in our review of the laws and regulations governing medical assistants, we did not find where it is permissible for a medical assistant to measure oxygen saturation nor administer oxygen. Furthermore, the criteria you provided are a series of tests that require a highly trained and educated professional to perform in order to ensure accurate results and patient safety. This criteria as you have described, require several assessments to which a medical assistant "may not diagnose or treat or perform any task that is invasive or requires assessment." Licensed professionals, such as respiratory care practitioners are educated and trained to ensure accurate results, which are dependent upon assessments. Respiratory care practitioners are also trained and educated to recognize hazards and complications which if unnoticed could result in serious patient harm.

Enclosed are all applicable laws and regulations (as of June 2003) surrounding medical assistants as well as the Respiratory Care Practice Act. You may also find more information regarding medical assistants at the Medical Board of California's website at: http://www.caldocinfo.ca.gov/ma.htm or by telephoning their office at (916) 263-2382.

---

[1] Medical Assistants practicing in the "outpatient" setting for a medical corporation or health care service plan may perform certain technical supportive services upon the specific authorization and supervision of licensed physician and surgeon or a licensed podiatrist.

"Specific Authorization" is defined as "a specific written order prepared by the supervising physician and surgeon or the supervising podiatrist...authorizing the procedures to be performed on a patient, which shall be placed in the patient's medical record, or a standing order prepared by the supervising physician and surgeon or the supervising podiatrist... authorizing the procedures to be performed, the duration of which shall be consistent with accepted medical practice. A notation of the standing order shall be placed on the patient's medical record."

"Supervision" is defined as "the supervision of procedures authorized by this section by the following practitioners, within the scope of their respective practices, who shall be physically present in the treatment facility during the performance of those procedures:

(A) A licensed physician and surgeon (B) A licensed podiatrist...."

Inquiry: I have a few questions that I hope you can answer for me or at least guide me to find the answer:

1) Does Life Support Equipment have to be calibrated by Licensed Personnel (RCP)? Or can it be done by a Respiratory Technician (not RCP) if that person has completed a competency in that area?

2) Where is it written that when a ventilator change is made, it must be documented on a ventilator flow sheet? And that an order has to be written for that change?

3) Do these rules apply only to RCPs or do they apply to RN and Doctors also?

4) If an RCP goes to do his/her ventilator check and the settings are all different without any new order written, do they have a legal right to change the ventilator back to the last written order?

Response: The Board has reviewed your inquiries and has the following comments to offer:

1. The calibration of life support equipment is not regulated by the Respiratory Care Board; however California Code of Regulations, Title 22 places that responsibility with the person who has day-to-day oversight of the respiratory care department. This is stated in section §70621. In that reference it states that all equipment must be calibrated according to the manufacturer's specifications and records of such calibrations shall be kept. It does not specify by whom the calibration must be performed.

2. Section 3702 of the Practice Act clearly defines the need for a physician's order for ventilator changes or other diagnostic and therapeutic procedures. It does not dictate where that setting or change should be documented. That process is usually determined by each individual organization and is detailed in their policies and procedures as to the requirements of that practice.

3. The process of having an order also applies to nurses as well. You can find reference to it in the Board of Registered Nurses, Nursing Practice Act, section 2725 (b). Physicians, by nature of their authority, are not required to write an order to make a change. However, it makes sense, from a patient safety perspective that physicians should write an order after making a change to ensure everyone knows the settings the patient is on. That issue is usually resolved at each facility and is not regulated by any agency that we are aware of.

4. If the RCP finds a patient on different ventilator settings than they have ordered I would hope the facility has some process in place to resolve this matter. From the Boards' perspective, it is not regulated by the Practice Act. From a practitioner standpoint, I would inquire with both the nurse and the physician before making any changes. If neither can confirm that they made a change, it seems appropriate to return the patient to their ordered settings and document the change appropriately.

...continued on page 12

Scope of Practice Inquiries & Responses

(continued from page 11)

Inquiry: Is it within the scope of practice of a licensed Respiratory Therapist to recover a patient, post bronchoscopy procedure, without the presence of an RN? There has been some concern at our facility in San Diego, California, that policy and Title 22 states an RN must be present. With the new nurse-to-patient ratio, alleviating a RN from this procedure would not only help with staffing issues, but may help increase the roll of the RCP and allow them to perform in a higher capacity towards their scope of practice. If this is allowed, can you tell me of any Hospital in California that may be doing this procedure with an RCP? Also, can a registered respiratory therapist administer the pre-medication for bronchoscopy under the supervision of an MD. (i.e.: Morphine, Versed, Demerol).

Response: The term "recover a patient" means many things in the acute care as well as the ambulatory clinic world of California. Usually, it is inferred that the patient has received general anesthesia, which does have criteria established in California Code of Regulations, Title 22 regarding nurses and their role in recovering these patients. In the case of most bronchoscopy procedures, they are usually done utilizing conscious sedation techniques with medications such as Versed, Demerol or Morphine. When the procedure is performed under these circumstances, then the post procedure term is usually referred to as observation and not recovery. If this is the case in your facility, then it would be acceptable for a licensed practitioner to provide this service. This is no different than the observation that licensed practitioners provide post treadmill, exercise PFT, Methylcholine challenge test or cardiopulmonary stress test. The therapist's role is to ensure that the patient successfully recovers and is able to be sent home safely after the procedure. Monitoring of sensorium, blood pressure, pulse, respirations, abnormal sputum as well as any other appropriate parameters is a very common and acceptable practice.

Additionally, it is also acceptable for the practitioner to administer any appropriate medications associated with the diagnostic procedure including their pre-procedure medication, as directed by a physician or as part of an established protocol.

I am not able to provide you with a list of references that currently practice this because the Board does not have that information. I would recommend you get a listing of hospitals in California and begin the task of researching this for yourself.

Inquiry: I am writing on behalf of the Respiratory Department at a Hospital in San Diego. Our Emergency Care Department has requested that RT's begin administering PO Prednisone to patients in the ED with history of RAD, during acute respiratory distress. What stance does the RCB of California have on this issue? Is there anything in our scope of practice that would prevent RT's from complying with request?

Response: Your request sounds as though you are considering implementing a protocol to approach a specific patient type with a specific initial presentation in your ED. If this is the case, than this practice is definitely within the scope of practice of a licensed practitioner and is detailed in section 3702(b) of the Practice Act.

Inquiry: I have a question regarding limited staffing at a hospital that requires RCP's to triage patient treatments. I work for a hospital that has decided a specific number of RCP's will be used in the facility regardless of the number of patients that have procedures ordered. In the past each procedure was given a procedure count. Then based on the number of procedures counted for the day a specific number of therapists were assigned to meet the needs of the facility at a safe staffing level. However, recently a new VP has been trying to cut costs and save the hospital money. I will also mention that this VP has no medical background and really does not understand our role in the hospital. He has decided that the maximum number of RCP's in the hospital for any shift is going to be 7. When normally we may have needed to run 8, 9, or 10 RCP's.

To give you an idea of our hospital we are roughly 300 beds with 3 adult ICU's, 1 NICU, a very busy ER, and the rest floor beds. This is where my question comes in. Now that this VP has mandated the number of RCP's, we are having to triage patient treatments. Not just 1 or 2, but patients that are in the hospital for acute pulmonary conditions with treatment orders of Q4 are lucky to see an RCP once in 12 hours. And the number of treatments being missed per day may be as high as 20 or more. My fellow RCP's and I in this facility are concerned because the winter season is just getting started and it places a great deal of pressure on the RCP to have to make the decision about who should get their ordered treatments and who can be missed. I also must state that we get many complaints from our patients, the doctors, the nurses, and the RCP is left apologizing to everybody. We believe that by the time the winter season hits in full force the RCP's will be triaging most if not all floor patients to deal with critical care units. The treatments that are going to be missed will probably reach 30-40+ on some days and the patients are going to suffer as a result. If the hospital would just return to counting procedures and staffing accordingly we would have the staff to provide safe therapy to all patients. Is this an issue for the Respiratory Care Board of California or should I be writing to another government agency for advice.

Response: Your question regarding appropriate staffing is a good one and has come before the Board before. From a staffing perspective, the Board does endorse the current American Association for Respiratory Care criteria for staffing guidelines. However, the Board does not have any guidelines or staffing ratios in place that deal with your question at hand. DHS and JCAHO, however, both have specific guidelines that address this issue of staffing and its relationship to your organization. The following are some excerpts from both the JCAHO and DHS (Title 22) that are specific to staffing:

JCAHO:

LD.2.4 Directors recommend a sufficient number of qualified and competent persons to provide care.

HR 2.1 The organization uses data on clinical/ service screening indicators in combination with human resource screening indicators to assess staffing effectiveness.

Examples Given:

Each department must select at least 4 clinical indicators and compare to human resource indicators to determine if there is a correlation between the two. One example might be pneumonia compared to staff vacancy rate or pneumonia to staff turn over rate.

Indicators are:

Overtime, staff vacancy rate, staff satisfaction, staff turnover rate, understaffing as compared to organization's staffing plan, nursing care hours per patient day, staff injuries on the job, on-call or per diem use, sick time, family complaints, patient complaints, patient falls, adverse drug event, injuries to patients, skin breakdown, pneumonia, postoperative infections, urinary tract infection, upper gastrointestinal bleeding, shock/cardiac arrest, length of stay.

DHS:

Title 22 Regulation references 70403, 70405, 70615, 70617 and 70619. There are also many medical groups that support the use of respiratory care practitioners but do not address staffing specifically. These groups include the American Thoracic Society, American Society of Anesthesia, California Thoracic Society to name a few. These letters of support can be accessed from the AARC's website or by calling them directly.

[Note: This inquiry was also referred to the Department of Health Services who conducted an investigation and issued a deficiency to the hospital.]

Inquiry: Is it in the scope of practice for a licensed RCP who is also NRP certified to assign and legally chart a neonatal APGAR score?

Response: It is the opinion of the Board that the ability of a licensed respiratory practitioner to assess and document the parameters associated with APGAR scoring is within the scope of their practice. The data elements of activity (muscle tone), pulse, grimace (reflex irritability) appearance (skin color) and respirations are all physiological data elements and are clearly defined in both the respiratory care practice act as well as the AARC scope of practice document.

It denotes the scope of the Respiratory Therapist as: The practice of respiratory care encompasses activities in: diagnostic evaluation, therapy, and education of the patient, family and public. These activities are supported by education, research and administration. Diagnostic activities include, but are not limited to: (1) obtaining and analyzing physiological specimens; (2) interpreting physiological data; (3) performing tests and studies of the cardiopulmonary system; (4) performing neurophysiological studies, and (5) performing sleep disorder studies.

Zinc Beneficial for Severe Pneumonia in Very Young Children

A study, as published in *The Lancet* found adjuvant treatment with 20 mg zinc per day accelerates recovery from severe pneumonia in children, and could help reduce antimicrobial resistance by decreasing multiple antibiotic exposures, and lessen complications and deaths where second line drugs are unavailable.

The study, conducted by W. Abdullah Brooks and colleagues from the International Centre for Diarrhoeal Disease Research, Banladesh, investigated whether zinc would help children diagnosed with pneumonia; a leading cause of morbidity and mortality in young children. Early reversal of severity signs—chest indrawing, hypoxia, and tachypnoea—improves outcomes.

In a double-blind placebo-controlled clinical trial in Matlab Hospital, Bangladesh, 270 children aged 2-23 months were randomized to receive elemental zinc (20 mg per day) or placebo, plus the hospital's standard antimicrobial management, until discharge. The outcomes were time to cessation of severe pneumonia (no chest indrawing, respiratory rate 50 per min. or less, oxygen saturation at least 95% on room air) and discharge from hospital. Discharge was allowed when respiratory rate was 40 per minute or less for 24 consecutive hours while patients were maintained only on oral antibiotics.

The group receiving zinc had reduced duration of severe pneumonia, including duration of chest indrawing, respiratory rate more than 50 per minute, and hypoxia, and overall hospital duration. The mean reduction is equivalent to 1 hospital day for both severe pneumonia and time in hospital.

You can find more information on this study at www.thelancet.com. Once at this website, select the "Search Journal" icon on the left side. Use the phrase, "pneumonia zinc" to search. Select the article titled "Zinc for severe pneumonia in very young children: double-bind placebo-controlled trial."

Scope of Practice on the Web

A compilation of scope of practice inquiries and responses over the last 2+ years are also available on the Board's website at:

http://www.rcb.ca.gov/

Once at this site, select the "Scope of Practice" link on the left side of the home page. Inquiries and responses may be selected by date or by subject.

MedWatch-*The FDA Safety Information and Adverse Event Reporting Program*

The FDA's MedWatch "E-List" delivers clinically important medical product safety alerts and concise, timely information about drugs and devices. Subscription to this service is free and may provide life-saving information for you, your family or your patients. Following are some examples of recent alerts:

Boston Scientific Taxus Coronary Stent 7/9/04
FDA and Boston Scientific Corporation notified healthcare professionals of a Class I recall of two lots of the Taxus drug-eluting coronary stent system (lots 6294706 and 6365192). Characteristics in the design of these two lots resulted in failure of the balloon to deflate and impeded removal of the balloon after stent placement. Impeded balloon deflation can result in significant patient complications, including emergency coronary artery bypass graft surgery and death.

Arjo Alenti Lift Hygiene Chair 7/9/04
FDA and Arjo Inc. notified healthcare professionals of a Class I recall of the Alenti Lift Hygiene Chair, a battery operated lift designed for lifting, moving and bathing of patients. There have been an increased number of incidents of the lifts tipping which have resulted in serious injuries to the patients. Reported causes of the incidents include lift instability on sloped floors, casters falling off of the lift while in use, patients leaning or shifting weight in the seat, and brakes not being applied. Additionally, the device labeling does not properly instruct the health care professional on how to properly secure the patient.

Carl Zeiss Ophthalmic System /VISULAS 532s with VISULINK 532/U surgical laser instrument 7/9/04
FDA and Carl Zeiss Meditec notified healthcare professionals of a Class I recall of one lot of VISULINK 532/U that may contain a defective mirror coating. This medical device is intended for use in laser treatment of diseases of the eye, particularly in treating retinal detachments or bleeding of the retina. The faulty mirror may misdirect the laser beam to an unintended target in or on the eye resulting in retinal bleeding and/or burns due to excessive laser energy in the eye.

Crestor (rosuvastatin) 6/9/04
FDA issued a Public Health Advisory notifying healthcare professionals of a revised package insert for use in the 22 member states of the European Union (EU). The changes to the European labeling are in response to adverse event reports in patients receiving Crestor and highlight certain patient populations who may be at an increased risk for serious muscle toxicity (myopathy) associated with Crestor use, especially at the highest approved dose of 40 mg. These risk factors and many of the recommendations for how to minimize the risk of myopathy are already captured in the FDA approved labeling for Crestor in the U.S. FDA alerted physicians to carefully read the Crestor product label and follow the recommendations for starting doses, dose adjustments, and maximum daily doses to minimize the risk of myopathy in individual patients.

Arjo MINSTREL Patient Lifts 5/27/04
FDA and Arjo, Inc. notified healthcare professionals of a Class I recall of the MINSTREL patient lift. There are two mechanical problems associated with the lifts: the first involves the hanger bar detaching from the lift, resulting in the patient falling to the ground because of a missing spring washer; the second problem involves a bolt in the foot pedal assembly becoming loose which allows the foot pedal assembly to fall off of the lift. This results in the lift becoming unstable and the patient possibly falling. Facilities should either inspect their lifts and follow the instructions in the Field Correction/Recall letter sent to all facilities or they should take the lifts out of service until they can be inspected by an Arjo service engineer.

Paradigm Quick-set Plus Insulin Administration Set 5/20/04
FDA and Medtronic, Inc. notified healthcare professionals of a Class I recall of Quick-set Plus infusion sets because of problems with bending of the infusion set's cannula or unintentional disconnection of the set at the insertion site that can interrupt insulin flow to diabetics who use them. These problems have resulted in a number of serious injuries, including some hospitalizations.

Children's Motrin Grape Chewable Tablets 5/12/04
FDA and McNeil alerted healthcare professionals that one manufacturing lot (Lot # JAM108, exp 1/06) of *Children's Motrin (ibuprofen) Grape Chewable Tablets* may mistakenly contain Tylenol 8-Hour extended release (acetaminophen) Geltabs. Lot # JAM108 was distributed nationwide to wholesale and retail customers between February 5 and April 1, 2004. The bottles are labeled as containing 24 tablets. The Tylenol 8-Hour product provides an adult dose of acetaminophen, and use of this adult product could provide more than the recommended dose (overdose) for children.

PRECISE RX Nitinol Stent Transhepatic Biliary System 5/04
Cordis and FDA notified healthcare professionals of a Class 1 recall for the ***revised instructions for use***, not cleared by the FDA, and contained in a notification mailed to Cordis' endovascular customers on March 29, 2004. Use of the stent system, indicated for treatment of obstruction of the bile duct due to malignancies, is reported to result in serious problems in some cases when used in the vascular system.

On May 4, 2004 Cordis sent a follow-up notification to customers describing nine patient injuries due to air embolism, including seizure and coma, as well as seven incidents of device malfunction in connection with the use of this system outside of its approved indication. Cordis stated that they were recalling the March 29, 2004 instructions with a strong recommendation that physicians limit their use of the PRECISE RX Stent to indicated uses only.

Effexor (venlafaxine HCl)/Effexor XR (venlafaxine HCl) 5/04
FDA and Wyeth Pharmaceuticals notified healthcare professionals of revisions to the WARNINGS, PRECAUTIONS, and DOSAGE AND ADMINISTRATION sections of labeling to alert healthcare providers of two important safety issues.

Neonates exposed to Effexor, other SNRIs (Serotonin and Norepinephrine Reuptake Inhibitors), or SSRIs (Selective Serotonin Reuptake Inhibitors), late in the third trimester of pregnancy have developed complications requiring prolonged hospitalization, respiratory support, and tube feeding. Such complications can arise immediately upon delivery.

Patients with major depressive disorder, both adult and pediatric, may experience worsening of their depression and/or the emergence of suicidal ideation and behavior (suicidality), whether or not they are taking antidepressant medications. The warning recommends patients being treated with antidepressants be observed closely for clinical worsening and suicidality, especially at the beginning of a course of drug therapy, or at the time of dose changes, either increases or decreases.

Absorbable Hemostatic Agents 4/2/04
The FDA Center for Devices and Radiological Health (CDRH) issued a Public Health Notification concerning a serious adverse event that can occur with the use of an absorbable hemostatic agent, a device used to promote coagulation and stop internal bleeding during surgical procedures. Since 1996, FDA has received reports of over 110 adverse events related to absorbable hemostatic agents. Eleven of the events resulted in paralysis or other neural deficits. These events continue to occur despite specific advice and warnings in the device labeling. CDRH provided recommendations to minimize the risk of adverse events in patients receiving an absorbable hemostatic agent during a surgical procedure.

Major Twice-A-Day 12 Hour Nasal Spray 3/18/04
Propharma, Inc., Miami, Florida issued a recall of Major Twice-A-Day 12 Hour Nasal Spray (Lot #K4496, Exp 10/06) because the lot was contaminated with Burkholderia cepacia bacteria. This product is a nasal decongestant containing the active ingredient oxymetazoline hydrochloride 0.05%. The entire lot was distributed nationwide to wholesalers, pharmacies, hospitals and retailers. Use of this contaminated product could cause serious or potentially life-threatening infections in patients with compromised immune systems, particularly individuals with cystic fibrosis. The lot number and expiration date are found on the bottom of the carton and the back of the bottle label.

Public Health Advisory: Antidepressant Use in Children, Adolescents, and Adults 3/22/04
The FDA asked manufacturers of the following antidepressant drugs to include in their labeling a Warning statement that recommends close observation of adult and pediatric patients for worsening depression or the emergence of suicidality when treated with these agents. The drugs that are the focus of this new Warning are: Prozac (fluoxetine); Zoloft (sertraline); Paxil (paroxetine); Luvox (fluvoxamine); Celexa (citalopram); Lexapro (escitalopram); Wellbutrin (bupropion); Effexor (venlafaxine); Serzone (nefazodone); and Remeron (mirtazapine).

Faaborg Patient Lifts 3/9/04
The FDA notified healthcare professionals of a Class I recall of Faaborg battery operated patient lifts distributed by Moving Solutions, Inc., of Downers Grove, Ill., because of a faulty design. Excessive wear of the main bolt, which secures the lift arm to the main frame of the patient lift, will cause the bolt to break which will cause the patient to fall and could result in serious injury, even death. FDA has received one report of death related to the failure of the bolt. Facilities should stop using these lifts until the problem is corrected.

Counterfeit contraceptive patches 2/4/04
FDA and Johnson and Johnson Co. of Raritan, NJ are warning the public about an overseas internet site selling counterfeit contraceptive patches that contain no active ingredients. The counterfeit contraceptive patches were promoted as Ortho Evra transdermal patches, which are FDA approved, and made by Johnson and Johnson's Ortho-McNeil Pharmaceutical, Inc. subsidiary. These counterfeit patches provide no protection against pregnancy. Consumers who have any of these products should not use them, but instead contact their healthcare providers immediately.

OTC pain and fever reducers 1/22/04
The FDA notified healthcare professionals of a national education campaign to provide advice on the safe use of over-the-counter (OTC) pain and fever reducers that contain acetaminophen and non-steroidal anti-inflammatory drugs (NSAIDs). The campaign is intended to raise consumer awareness of these safety issues and to inform healthcare providers about the role that they can play in preventing acetaminophen induced hepatotoxicity and NSAID-related gastrointestinal bleeding and renal toxicity in patients using these medicines.

If you would like more information on any of these product safety alerts, visit the FDA's MedWatch website at: www.fda.gov/medwatch/index.html. To receive immediate updates, subscribe to the "E-List" at: http://www.fda.gov/medwatch/elist.htm.

A Message from The Medical Board of California, Enforcement Program

As chief of enforcement for the Medical Board of California, I am extremely interested in advancing the board's mission of consumer protection. Recently a nurse in a California hospital was quoted in a major newspaper article stating that she knew (without naming anyone) of many physicians who deserved to have their licenses revoked by our board. The context for this was within a story about a licensee whose license was being revoked by our board. Such a statement is of concern to us, because we rely in part on peer review and input from allied health professionals to help us in doing our job of patient protection. In my opinion, healthcare workers are in a uniquely qualified position of trust and obligation to report to regulatory agencies problems they see with other healthcare providers that lead to or could lead to patient harm.

I am asking those "on the front line" to recognize and act on this obligation by informing the Medical Board of physician misconduct of which they become aware. While we can take complaints anonymously, they are impossible to pursue if we cannot find witnesses to corroborate the allegations. I cannot guarantee your name will not surface, but we will work with you to avoid that if possible. I can guarantee you that you will be doing the right thing by your patients and your profession. We, at the board, are deeply committed to our mission of consumer protection, and the proper licensing and regulation of physicians in California. We hope you will work with us and your constituencies toward that end.

Please call our toll-free complaint line at (800) 633-2322, or download our complaint form from our website at www.caldocinfo.ca.gov or www.medbd.ca.gov. Thank you on behalf of the consumers of the State of California.

--- Joan Jerzak, Chief of Enforcement, Medical Board of California

The Disciplinary Process, Stay Involved! *(continued from page 9)*

While the law must be applied evenly to all cases, the Board recognizes that extenuating circumstances often exist and are unique in every case. Consideration is given to mitigating or aggravating evidence when staff are recommending discipline as well as when Administrative Law Judges and the Board order discipline to be imposed. The Board's disciplinary guidelines provide the following examples of such evidence:

Evidence in ***Mitigation*** of Penalty

Recognition by Respondent of his or her wrongdoing and demonstration of corrective action to prevent recurrence.

Respondent was forthcoming and reported violation or conviction to the Board.

A substantial amount of time since the violation or conviction occurred.

No prior criminal or disciplinary history.

Evidence in ***Aggravation*** of Penalty

Patient's trust, health, safety or well-being was jeopardized.

Patient's or employer's trust violated (i.e. theft, embezzlement, fraud, etc...).

Violations involved or were in the presence of children.

History of prior discipline.

Patterned behavior: Respondent has a history of one or more violations or convictions related to the current violation(s).

Perjury on official Board forms.

Violent nature of crime or act.

Violation of Board Probation.

Failure to provide a specimen for testing in violation of terms and conditions of probation.

Approximately 70% of cases referred for formal disciplinary action are settled between the RCP and the Board without a formal hearing; 15% proceed to a formal hearing, and 15% end in a "default decision."

Approximately 70% of cases referred for formal disciplinary action are settled between the RCP and the Board without a formal hearing; 15% proceed to a formal hearing, and 15% end in a "default decision." Stipulated settlements are advantageous to both parties as the Board has the authority to reduce penalties as outlined in its disciplinary guidelines in the interests of saving time and expense. Whereas, Administrative Law Judges are constrained to the disciplinary guidelines as they are written and often their orders result in the same or more severe discipline than may have been previously offered through a stipulated agreement. When an RCP fails to file a "Notice of Defense," a message is sent that the RCP has chosen not to participate in the process which results in a "default decision." Default decisions can often result in harsher discipline primarily because some forms of discipline (i.e. probation) are not viable with an unwilling participant.

Practitioner involvement in the disciplinary process is often a critical factor in the level of discipline ordered. The Board's enforcement analysts are trained and experienced professionals who are always available to provide information on the disciplinary process and assist an RCP with his/her case or provide direct contact information for the DAG handling the case. Likewise, DAGs will also provide helpful information and options available to a practitioner who has been served with an accusation.

Practitioner involvement in the disciplinary process is often a critical factor in the level of discipline ordered.

It is the responsibility of each licensed RCP to ensure his/her current address is reported to the Board in writing within 14 days of any change. Not only does this ensure the practitioner will be notified of any formal disciplinary action being taken, but it will also ensure renewal applications and other important materials are received. It is also incumbent upon each practitioner who has been served with a formal accusation to take immediate and appropriate action to ensure he/she has the opportunity to participate in any disciplinary proceeding.

For more information, please contact the Board office and request to speak to an enforcement analyst.

Disciplinary Actions Definitions

Final Decisions become operative on the effective date, except in situations where a stay is ordered.

An **Accusation** is the legal document wherein the charge(s) and allegation(s) against a licensee are formally pled.

A **Statement of Issues** is the legal document wherein the charge(s) and allegation(s) against an applicant are formally pled.

An **Accusation and/or Petition to Revoke Probation** is filed when a licensee is charged with violating the terms or conditions of his or her probation and/or violations of the Respiratory Care Practice Act.

To order copies of legal pleadings, please send a written request, including the respondent's name and license number (if applicable), to the Board's Sacramento office or e-mail address.

FINAL DECISIONS
PUBLIC REPRIMANDS

Bailey, Joyce Elaine, RCP 10463
Berdrow, John Robert, RCP 6761
Berg, Robert Charles, RCP 3492
Blanco, Cynthia, RCP 23439
Brown, Eric Clifton, RCP 9108
Butenko, Nataliya S., RCP 23463
Caluag, Jose Deleon, RCP 19455
Claridy, Robert L., RCP 17919
Cubbin, Richard C., RCP 1347
Guadarrama, Ralph, RCP 5670
Hunter, Kim Anthony, RCP 11849
Johnson, Rondalee, RCP 11661
Kim, Wesley Sang, RCP 15217
Legere, Bill Joseph, RCP 3520
Mahoney, Kevin, RCP 23424
McCartney, Ian A., RCP 18355
Quint, Eric Alden, RCP 3113
Rosenfeld-Coty, Terry R., RCP 8437
Santana, Sherri Ann, RCP 20067
Schisler, Cathleen M., RCP 14521
Serrano, Salim A., RCP 21461
Stabile, Valentino D., RCP 23418

FINAL DECISIONS
CITATIONS & FINES

Banuelos, Salvador J., RCP 22978
Beghtol, Robert A., RCP 22180
Berryman, Johnnie Bell, RCP 4727
Butler, Daniel, RCP 16351
Caples, Gregory Allen, RCP 18018
Carrington, Giselle D., RCP 22327
Gallardo, George, RCP 12295
Green, Keturah Charmel, RCP 20709
Hardy, Darryl R., RCP 15924
Hernandez, Ismail Jr., RCP 23505
Howard, Aaron J., RCP 19006
Hughes, Telly S., RCP 20040
Ismail, Abdullah, RCP 7786
Jackson, Edward J., RCP 19869
Jones, Dawn M., RCP 11578
Kramlich, William J., RCP 13286
Lozano, Gabriel, RCP 17470
Marcial-Armenta, Monica, RCP 14679
Martin, Laura L., RCP 15435
Mendez, Robert Daniel, RCP 16004
Millimaki, James A., RCP 21032
Monger, Stephen Lyman, RCP 9080
Parra, Rudy, RCP 21670
Paterson-Ford, Sherry, RCP 18673
Penn, Gina Lynn, RCP 9173
Porras, Alturo, RCP 18416
Razo, Alfred, G., RCP 16018
Robinson, Carolyn A., RCP 2866
Ruetz, Susan Helene RCP 14739
Saavedra, Daniel F., RCP 5880
Saliba, Sam Ibrahim, RCP 5264
Sandoval, Nikki L. , RCP 22492
Scofield, Steve K., RCP 6947
Shelton, Jason P., RCP 21309
Stites, Grethen A., RCP 21533
Thoman, Bobbie J., RCP 22535
Vitthal, Ritu, RCP 20264
Witzig, James, RCP 16505

FINAL DECISIONS
REVOKED OR SURRENDERED

Astorga, Steve Javier , RCP 21004
Baranczyk, Terri Lynn, RCP 5607
Beljan, Gerald, RCP 15317
Brown, Gayla Marie, RCP 16864
Diwa, Jonathan Taylor, RCP 22785
Dorsey, Larry Allen, RCP 14698
Egert, Janet S. Haynes, RCP 4247
Hernandez-Castillo, Reuben, RCP 19356
Howard, Colin C. II, RCP 1034
Huch, Steven, RCP 4904
Miller, Joe V., RCP 4286
Nichols, James R., RCP 6478
Porche, Ronland B., RCP 13562
Sousa, Bonnie, RCP 17084
Steed, Reginald D. RCP 10870
Straw, Valerie Jean, RCP 14098
Templeton, Stephanie, RCP 18775
Ullum, Michael Vern, RCP 19814
Vasquez, Angela Louise, RCP 15412
Vierra, Denise L., RCP 4257

Disciplinary Actions

January 1 - June 30, 2004

FINAL DECISIONS
PLACED ON PROBATION / ISSUED CONDITIONAL LICENSE

Becker, Jamie, RCP 18014
Chilson, Beverly J., RCP 6217
Connel, Allan, RCP 23512
Davis, Marshall A. Jr., RCP 23433
Dodds, Laura L., RCP 21067
Ferguson, Allan W., RCP 1922
Gatchell, David F., RCP 22524
Geesman, Robin Ann, RCP 19549
Higgs, Cheryl, RCP 15800
High, Jayson Scott, RCP 16591
Hill, David W., RCP 9670
Johnson, David L., RCP 13732
Joseph, Benny Punnen, RCP 20504
Lagutaris, James R., RCP 16811
Mahoney, Cynthia Marie, RCP 7642
Mann, Michael Allan, RCP 18734
Richman, Pamela Anne, RCP 20063
Rocero, Roy Allan Sr., RCP 14982
Stratton, Stephen John, RCP 19339
Syed, Nasreen, RCP 12930
Van, Binh Thanh, RCP 14737
White, John David, RCP 11059

ACCUSATIONS

Agacer, Austin M. Jr., RCP 7946
Albrecht, Donald, RCP 7554
Baldwin, Stanley M., RCP 8779
Bob, Ioan Jr., RCP 19217
Boone, Vicky, RCP 20925
Byers, Angela, RCP 14926
Campbell, Shari Lynn, RCP 2295
Catron, Jerry Lee, RCP 20965
Clevenger, Thomas D., RCP 22729
Cunningham, Kim M., RCP 16251
Drakakis, Alex Nick, RCP 21299
Elgin, Leslie, RCP 18628
Fowler, Lorraine Ann, RCP 5464
Funk, James William, RCP 21686
Gomez, Christina Maria, RCP 3296
Gutierrez, Patricia D., RCP 16912
Haro, Harry Jess, RCP 12668
Hernandez, Manuel, RCP 15354
Hoyt, Nancy J., RCP 8114
Iravani, Amir Mohsen, RCP 14201
Johnson, Vincent Craig, RCP 10527
Jones, Viola, RCP 19621
Koch, Sally J., RCP 21393
Marifosque, Edgardo Era, RCP 20002
McNair, Leroy C., RCP 6291
Modelo, Shawn S., RCP 2637
Park, Casey C., RCP 22039
Pereyda, Juan Carlos, RCP 20756
Perry, Frank J., RCP 22674
Pineira, Ray P., RCP 12417
Rios, John Ambrose, RCP 5442
Rowell, Scott, RCP 4692
Simpson, Pamela Louise, RCP 13212
Spetnagel, William Carl, RCP 17762
Stanich, Cliff Mark, RCP 9093
Traudt, Mark P., RCP 11043
Unutoa, Irene, RCP 9267
Watson, Mitchell P., RCP 9271
Whigham, Carl E., RCP 20619
Wing, Roger M., RCP 10061
Young, Jeffery Keith, RCP 1701

ACCUSATIONS AND/OR PETITIONS TO REVOKE PROBATION

Battle-Montoya, Susan, RCP 16238
Mendoza, Charles L., RCP 16621
Nicolas II, Rafael R., RCP 20078

STATEMENTS OF ISSUE

Alexander, Calvin
Grijalva, Lanore Campos
Kirk, Jody Michelle
Lewis, Sheryl Elaine
Mason, Gregory
Millwee, Fay Ann
Ramirez, Hugo E.
Sams, Suzanne M. aka Tobin
San Lee, William Jesus
Sykora, Deborah Anita

Notice on Collection of Personal Information

The Respiratory Care Board of California of the Department of Consumer Affairs collects personal information requested on many of its forms as authorized by Sections 30 and 3730 of the Business and Professions Code. The Board uses this information principally to identify and evaluate applicants for licensure, issue and renew licenses, enforce licensing standards set by law and regulation, and collect outstanding costs ordered in final decisions resulting from enforcement action.

Mandatory Submission. Submission of the requested information is mandatory. The Board cannot consider your application for licensure or renewal unless you provide all of the requested information.

Access to Personal Information. You may review the records maintained by the Board that contain your personal information, as permitted by the Information Practices Act. See below for contact information.

Possible Disclosure of Personal Information. We make every effort to protect the personal information you provide us. The information you provide, however, may be disclosed in the following circumstances:

- In response to a Public Records Act request (Government Code Section 6250 and following), as allowed by the Information Practices Act (Civil Code Section 1798 and following);
- To another government agency as required by state or federal law; or
- In response to a court or administrative order, a subpoena, or a search warrant.

Address of Record. Please be advised that your address of record is not considered personal information and may be disclosed to the public. However, the Board will attempt to notify a licensed Respiratory Care Practitioner prior to releasing an address of record (if it appears the address may be a home address).

Contact Information. For questions about this notice or access to your records, you may contact the Respiratory Care Board at 444 North 3rd Street, Suite 270, Sacramento, CA 95814; Toll-free: (866) 375-0386, or e-mail: rcbinfo@dca.ca.gov. For questions about the Department of Consumer Affairs' privacy policy or the Information Practices Act, you may contact the Office of Privacy Protection in the Department of Consumer Affairs, 400 R Street, Sacramento, CA 95814, (866) 785-9663 or e-mail privacy@dca.ca.gov.

Mandatory Reporting

Respiratory care practitioners (RCP) and their employers are required by law to report violations of the Respiratory Care Practice Act and the regulations governing the practice of respiratory care to the Board.

RCPs are required by law to report to the Board any person that may be in violation of, or has violated, any of the laws and regulations administered by the Board. Licensees are required to make such a report to the Board within 10 calendar days from the date he/she knows or should have reasonably known that a violation or probable violation occurred.

Employers are required by law to report to the Board, within 10 days from the date of a suspension or termination of any RCP in their employment, for any one or more of the following causes:

- Use of controlled substances or alcohol that impairs an RCP's ability to safely practice;
- The unlawful sale of controlled substance(s) or prescription item(s);
- Patient neglect, physical harm to a patient, or sexual contact with a patient;
- Falsification of medical records;
- Gross incompetence or negligence, and
- Theft from patients, other employees, or the employer.

RCPs are subject to discipline and can be fined up to $2,500 and employers are subject to a fine up to $10,000 for failure to make a report as required. Consideration is given to mitigating and aggravating circumstances surrounding the case.

Retired License Status

As of January 1, 2004, licensees have the option of placing their license in a retired status.

What exactly does "retired status" mean? It means that a licensee may request that his or her license status be updated to "retired," relieving the licensee from all renewal and reporting requirements without his or her license labeled "delinquent" or "canceled," while still continuing to receive newsletters and other similar information.

An important thing to consider before making a decision to place your license in a "retired status," is that this status rescinds all privileges to practice respiratory care in California.

If you think this is something you may be interested in, please contact the Board's office to obtain additional information and a Request for Retired Status form, which can also be obtained by visiting the Board's website at www.rcb.ca.gov and clicking on the "Licensing" link.

The Joint Commission on Accreditation of Health Organizations Sentinel Event Alert

The birth of child – a joyous, celebratory event – can sometimes turn to tragedy when the infant dies during delivery at the hospital. Better communication among caregivers could reduce the risk of these infant deaths, according to an alert issued today by the Joint Commission on Accreditation of Healthcare Organizations.

The Joint Commission's study of infant deaths and major injury reported through its health care errors database finds that nearly three-quarters of hospitals cited communication breakdowns as a major reason for these devastating events. These communication issues include a lack of teamwork; not following the chain of communication; and an atmosphere that discourages team members from speaking up. Staff competency and training, inadequate fetal monitoring and unavailability of monitoring equipment and/or drugs also are listed as root causes.

The Joint Commission alert to more than 4,500 accredited hospitals nationwide is designed to create new awareness of the problem and offer practical solutions to keep the smallest and most vulnerable patients safe. To reduce the risk of infant deaths and major injuries, the Joint Commission's *Sentinel Event Alert* newsletter recommends that hospitals:

Conduct formal team training sessions for the obstetrical/perinatal team.

Use care guidelines established by the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and the Association of Women's Health, Obstetric and Neonatal Nurses.

Develop clear procedures for fetal monitoring of potential high-risk patients.

Take steps to ensure key personnel are available for emergency interventions.

Make certain that neonatal resuscitation areas are fully equipped and functioning.

The warning about infant deaths is the latest in a series of alerts issued by the Joint Commission, which has established one of the nation's most comprehensive voluntary reporting systems for health care errors. Previous alerts have focused on wrong-site surgery, deadly medication mix-ups, health care acquired infections, patient suicides, infant abductions and fatal falls among the elderly. This database identifies the causes of errors, enabling the Joint Commission to warn facilities about dangers and share solutions to prevent these tragedies. The complete list and text of past issues of *Sentinel Event Alert* can be found on the Joint Commission's website: www.jcaho.org.

Policy on Nondiscrimination on the Basis of Disability and Equal Employment Opportunity Statement

The Respiratory Care Board of California does not discriminate on the basis of disability in employment or in the admission and access to its programs or activities. The Executive Officer of the Board has been designated to coordinate and carry out this agency's compliance with the nondiscrimination requirements of Title II of the Americans with Disabilities Act (ADA). Information concerning the provisions of the ADA, and the rights provided thereunder, are available from the ADA Coordinator.

Respiratory Care Board of California
444 North 3rd Street, Suite 270
Sacramento, CA 95814

FIRST-CLASS MAIL
U.S. POSTAGE
PAID
PERMIT NO. 424
SACRAMENTO, CA

Address Change Notification

Remember, you must notify the Board in writing if you have changed your address of record within 14 days of such change. Failure to do so could result in a $25-$250 fine.

Your written request must include your RCP number, your previous address, your new address, and your signature.

The Board office will accept requests received by U.S. Mail, faxed notifications and changes made via the Board's website.

OSP 04 85625